AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

BROOMFIELD PEDIATRICS
an affiliate of Community Reach Center

Patient name: _____ **DOB:** _____

Parent/Guardian name: _____ **Phone number:** _____

Release From: The following organizations/providers are hereby authorized to release and share oral and written health information with each other, regarding the Patient named above:

Company/Organization/Person and Relationship: _____

_____

_____

Address:

(____)_____ –_____ (____)_____ –_____

Phone: **Fax:**

_____

Email:

Release To:

Company/Organization/Person and Relationship: _____

_____

_____

Address:

(____)_____ –_____ (____)_____ –_____

Phone: **Fax:**

_____

Email:

Purpose(s) or need for which the information is to be used and disclosed: (Please check as applicable)

❑ Coordination/Continuity of Care
❑ Disability Determination
❑ Legal Purposes
❑ Other (Specify): _____

Information to be released, exchanged, and shared: (Please check next to the documents to be released & exchanged)

❑ Complete Medical Record
❑ Physician's Orders and Encounter Notes
❑ Legal Records and Information
❑ Growth Charts
❑ Immunization Records
❑ Treatment Plan
❑ History and Physical Exam
❑ Psychiatric/ Psychological Eval/Notes
❑ Labs
❑ Other (Specify): _____

Please initial the below statements:

_____ *Initial* I UNDERSTAND the information requested may include evaluation, diagnosis or treatment information regarding the following conditions: mental illness, alcohol or drug abuse, and HIV/AIDS. I understand that this information may include, when applicable, information relating to sexually transmitted diseases including Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome, or AIDS related Complex) and any other communicable diseases

_____ *Initial* I UNDERSTAND that I may revoke this Authorization at any time by giving written notice to the Center, except to the extent that the Center has already taken action on this request. This Authorization will expire on _____ (date), or, if left blank, **TWO YEARS** from the date of my signature (whichever event comes first). I release the Center from all liability for disclosing the requested information. I UNDERSTAND that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization

AUTHORIZATION: I understand that authorizing the disclosure of this information is voluntary. This Authorization may be used and re-used to obtain information learned and records prepared after the date this release was signed as long as this Authorization remains valid. I understand that when information is release, it carries with it the potential for unauthorized re-disclosure and it may no longer be protected by federal confidentiality rules such as HIPAA. A copy or facsimile of this Authorization may be used with the same effectiveness as the original.

_____ _____

Patient OR PERSON AUTHORIZED TO SIGN FOR CONSUMER **Date**

_____

Print name if not the Patient and state how authorized to sign

_____ _____

WITNESS SIGNATURE and Printed Name **Date**

_____ *Initial* **I attest that I have legal guardianship of the above Patient and/or have authority to make medical decisions on their behalf.**